

MEDI-CAL WITH OTHER HEALTH COVERAGE (OHC)

These are the instructions for Medi-Cal with Other Health Coverage (OHC):

1. Contact the OHC and verify if the client has insurance or Other Health Coverage (OHC) and if mental health (MH) services are covered.
2. If there is OHC and MH care is covered, obtain authorization from OHC to treat client and bill OHC.
3. Refer the client back to OHC if OHC covers MH services but refuses to grant authorization and require that the client obtain services at their own OHC facility. The OHC is responsible to provide care until client's benefits are used up. For example, if the OHC plan allows 20 MH treatments per year, the client must obtain 20 treatment sessions with OHC providers before the client can be accepted for treatment within the County network of directly operated and contract providers.
4. If you were informed by the OHC that the client does not have insurance with the company, you will have to do the following: (a) Document the statement made by OHC representative including the date, time, and name of OHC representative. (b) You also need to advise the client and refer the client to Department of Public Social Services (DPSS) to have their Medi-Cal record corrected to show there is no OHC.
5. Accept the client for treatment ONLY IF (a) client has no insurance or OHC; (b) there is OHC but MH care is not covered by OHC; or (c) client has used up their MH benefits - but when client's benefits are renewed, usually in January, client must be referred back to OHC for their treatment.
6. If #5 applies (no OHC/ MH not covered / MH benefits have been used up), documentation is required. Acceptable documentations are: (a) Denial of your claim after submitting your claim to OHC for payment, (b) written statement from OHC that client has no MH coverage or benefits have been used up, or (c) your documentation if you have spoken with OHC representative and you were told that there's no MH coverage or benefits were used up. For (c), you need to document the date/time, name of OHC representative and the statement made by OHC.

7. If you provided emergency treatment or your services have been authorized by OHC, bill OHC (electronically through your own system, if you have the capability) or manually by using HCFA-1500 or CMS-1500 or OHC's claim form. You also need "INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS" signed by client before billing OHC. See manual on "Private Insurance Billing" for billing OHC.
8. Bill the remaining balance to Medi-Cal as cross-over claim with insurance and enter the amount paid by OHC. Enter \$0 if #5 applies with required documentation (claim denial or written statement indicating that client has no OHC; or no MH coverage; or client's MH benefits were used up).

DO NOT BILL MEDI-CAL if you did not follow these instructions. These are requirements mandated by State and federal statutes before you can bill Medi-Cal with OHC. If you billed Medi-Cal and you were paid, there is a chance that you will be charged back if State audit is conducted. If you did not follow the instructions, you may bill CGF. You will be reimbursed through CGF if you have available CGF; if not, you will not get paid. You may also bill any other third party payor, if there's any.

If you accept a Medi-Cal client with OHC for treatment, the client will be liable to pay for the UMDAP, the Medi-Cal Share of Cost (SOC), or the cost of care, whichever is the least amount.

It helps a lot if you understand the OHC codes you see in the client's eligibility screen (MOPI). By knowing what the codes stand for, you will be able to determine if you may bill Medi-Cal directly without obtaining OHC verification, authorization and other documentations. For Example: if there is no (O I M) under COV, it means there is no Outpatient/Inpatient/Medical coverage indicated. Without O I M, the client does not have any health benefits and therefore, no MH benefits either. (O M) means the client has Outpatient Medical benefits. "I" only means they only have Inpatient benefits. If no O, I, or M, they may only have benefits for D (dental), or V (Vision), or L (long Term Care), etc. Having no O I M under coverage is sufficient documentation that there is no MH coverage. In this case, you do the cross-over billing in IS and indicate \$0 as amount paid by the insurance and the whole unit of service will be balance billed to Medi-Cal.